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This study examined relationships between masculinity ideologies, perceived discrimination, and parenting behaviors on depressive symptoms and drinking behavior among 332 nonresident African-American fathers. Masculinity ideologies also were examined as moderators of perceived discrimination and parenting behaviors on outcomes. Results from hierarchical regression analyses showed that culturally based traditional masculinity was associated with less depressive symptoms. Perceived discrimination was linked to more depressive symptoms; however, positive relationships with sons were associated with less depressive symptoms and drinking behavior among fathers. Parenting behaviors explained additional variance in depressive symptoms and drinking behavior after controlling for masculinity ideologies, perceived discrimination, and sociodemographics. More cooperative parenting behaviors between fathers and mothers were associated with more depressive symptoms among fathers with high interconnected masculinity beliefs. Strategies for incorporating masculinity ideologies and the fatherhood role into interventions, clinical practice, and policies to improve the mental health and health behaviors of nonresident African-American fathers are discussed.

Keywords: masculinity, African-American fathers, father–son relationships, depressive symptoms, drinking behavior, parenting

Men are less likely to engage in health promoting behaviors than women, resulting in their markedly worse health outcomes (Garfield, Isacco, & Rogers, 2008; Xanthos, Treadwell, & Holden, 2010). This is especially true for African-American men, who have the lowest life expectancy and highest mortality rates compared with men in other racial/ethnic groups in the United States (Centers for Disease Control & Prevention, 2011). Many African-American men are disadvantaged because of economic, environmental, and psychosocial stressors, which place them at risk for depression and substance abuse at young adulthood and midlife when several major life transitions occur (Sellers, Bonham, Neighbors, & Amell, 2009; Xanthos et al., 2010).

Gender and racial/ethnic disparities in depression and substance abuse among men persist partially because lower socioeconomic status (SES) and chronic experiences with racism and discrimination remain prevalent contributing to a lack of access to adequate health care for African-American men (Williams, Neighbors & Jackson, 2003). In addition, access to treatment is often hindered by masculine ideo-

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logical beliefs that characterize help seeking as a "weakness." For example, African-American boys often are socialized to be self-reliant, which can establish negative health beliefs and behaviors based on masculine ideologies early in life (Bailey, Blackmon, & Stevens, 2009; Oliffe & Phillips, 2008). Recent research suggests these beliefs and behaviors may be altered as men encounter new role transitions and life demands (Kerr, Owen, Wiesner, & Pears, 2011; Warner & Hayward, 2006).

One novel consideration in promoting men's health is the fatherhood role. Studies of the transition to fatherhood of primarily White resident fathers have found positive health behavior changes in several areas including substance use (Garfield, Clark-Kauffman, & Davis, 2006; Kerr et al., 2011). Less is known about fatherhood as a health promotion strategy among nonresident African-American fathers of older children, even though father involvement among nonresident fathers has increased considerably over the past 25 years (Amato, Meyers, & Emery, 2009; King & Sobolewski, 2006), and African-American nonresident fathers have been found to be more involved with their children than nonresident fathers of other racial/ethnic groups (Edin, Tach, & Mincy, 2009; King, Harris, & Heard, 2004).

The purpose of this study was to examine masculinity ideologies, perceived discrimination, and parenting behaviors as correlates of depressive symptoms and drinking behavior among nonresident African-American fathers and to determine whether different masculinity ideologies moderate the association between perceived discrimination and parenting behaviors on fathers' depressive symptoms and drinking behavior. The ultimate goal was to produce findings that could inform interventions, clinical practice, and policies designed to address the health and well-being of nonresident African-American fathers.

Depressive Symptoms and Drinking Behavior Among African-American Fathers and Men

Available studies indicate that approximately half of nonresident African-American fathers experience moderate to severe levels of depressive symptoms (Anderson, Kohler, & Letieq, 2005; Davis, Caldwell, Clark, & Davis, 2009). This means a substantial number of these fathers may be at risk for depression. Understanding risk factors for depression among nonresident fathers is noteworthy because it has implications for their ability to engage with their children (Davis et al., 2009), and depression places them at risk for other illnesses such as stroke, cardiovascular disease, diabetes, and substance abuse (Bonhomme, 2007; Xanthos et al., 2010).

In a national assessment of changes in the prevalence of major depression and substance use from 1991–2002, Compton and colleagues (2006) found increases in rates of depression in general. Increases in rates of substance abuse, however, were only among 18- to 29-year-old African-American males who also had increases in rates of depression. This suggests a vulnerable group of African-American men at a time when many life transitions occur, such as family formation and fatherhood. Although the actual rate of drinking for African-American men is lower than that for White men, more African-American men who drink manifest alcohol-related health problems (Sellers et al., 2009) and engage in heavy drinking in alarming numbers (Caetano, Clark, & Tam, 1998). Jackson and colleagues (2010) describe this pattern of heavy drinking as a reflection of ineffective coping with life stressors among African-American men. Using substances to deal with depression (Courtenay, 2000) or feelings of powerlessness (Mullen, Watson, Swift, & Black, 2007) may be how marginalized men construct their manhood in this society.

Multiple Masculinity Ideologies and African-American Men

Dominant hegemonic masculinity ideologies are defined as reflecting power and prestige or status characterized by physical toughness, competiveness, autonomy, and emotional detachment (Tannenbaum & Frank, 2011). Men often face societal pressures to portray qualities of autonomy, strength, and self-sufficiency through the enactment of risky health behaviors (Courtenay, 2000). Numerous studies have found that men who uphold such traditional views of masculinity exhibit greater risky health behaviors such as drinking, smoking, and using drugs (Courtenay, 2003; Mahalik & Burns, 2011; Mullen et al., 2007). Men with such tra-

ditional masculinity beliefs often deny their emotions and feelings and have been found to report more anxiety, depression, as well as psychological stress than those with less traditional masculinity beliefs (Anderson et al., 2005; Courtenay, 2000; Garfield et al., 2008).

Research assessing traditional masculinity through a cultural lens indicates conflicting findings for African-American men with some studies finding more endorsement (Levant & Richmond, 2007), while others find less endorsement of traditional masculinity ideologies than White men (Abreu, Goodyear, Campos, & Newcomb, 2000). Consistent in this literature is that African-American men endorse aspects of traditional masculinity ideological beliefs (e.g., aggressiveness, self-reliant), while also endorsing less traditional masculine norms such as being communal, egalitarian, and spiritual (Hammond & Mattis, 2005; Hunter & Davis, 1994).

Distinctions in what are considered dominant hegemonic or traditional masculinity ideologies and less traditional masculinity ideologies that are culturally based are the emotional expressions associated with family among African-American men and interpersonal interactions external to family reflecting interconnections with others and the community (Hammond & Mattis, 2005; Hunter & Davis, 1994). Thus, culturally based masculinity that includes interpersonal competencies involving family and concerns for others appear to be a part of the construction of masculinity for some African-American men. How different masculinity ideologies are expressed may vary by the social environment in which they are operationalized.

Phillips (2001) demonstrated the significance of understanding the fluidity of masculinity within a specific context in her qualitative study of the construction of manhood in prison. She noted the need for adaptations in masculinity among diverse groups of men in an environment with extreme social control. A process of social mapping commonalities and connections to others was used to construct and publicly display manhood, but self-reliance reemerged when necessary to survive. Thus, masculinity can be thought of as a fluid social identity rather than a static personality trait (Connell & Messerschmidt, 2005; Phillips, 2001).

Perceived Discrimination, Depressive Symptoms, and Drinking Behavior

Extensive research confirms the deleterious effects of perceived discrimination on African-American men's physical and mental health (Hammond, 2012; Sellers et al., 2009; Utsey & Payne, 2000; Watkins, Green, Rivers & Rowell, 2006; Williams et al., 2003; Xanthos et al., 2010). However, the connection between discrimination, masculinity beliefs, and these outcomes rarely has been examined. In a recent study, Hammond (2012) found that restrictive emotions moderated the relation between racial discrimination and depressive symptoms among older African-American men, suggesting this masculinity belief may be protective against racial discrimination for a specific group of African-American men. Other masculinity beliefs may be risk factors for poor outcomes for other men. For example, most nonresident fathers must negotiate with systems (e.g., courts, Child Welfare) and with mothers to maintain a relationship with their children. If they endorse masculinity beliefs emphasizing power and control, discriminatory experiences may be exacerbated rather than reduced.

Coparenting Among Nonresident Fathers and Mothers

Coparenting is a dynamic family process defined as cooperation and agreement between parents in raising children (Carlson et al., 2008). In most nonresident families, mothers have legal and physical custody of the children; therefore, they may regulate or act as "gatekeepers" over nonresident fathers' involvement with their children (Carlson et al., 2008; Isacco, Garfield, & Rogers, 2010). The experience of coparenting between nonresident fathers and mothers has implications for the fathers' mental health and health risk behaviors. Anderson et al. (2005), for example, found that about half of low income nonresident African-American fathers experienced conflict with mothers in raising their children. As the number of conflicts increased, fathers' levels of depression increased. Using data from the Fragile Family and Child Well-being Study, Wilson and Brooks-Gunn (2001) found that nonresident fathers who did not have a good relationship with their children's mother were more likely to exhibit de-

pressive symptoms, engage in illicit drug use, and smoke compared with fathers who had good relationships.

Quality of Relationship With Children and Fathers' Health Behaviors

Social ecological models of family life (Bronfenbrenner, 1977) posit bidirectional links between parents and children, suggesting that parent–child relationships should have benefits for both children and parents. Thus, the quality of the parent–child relationship may be a critical pathway for improving the health and well-being of nonresident fathers. Because fatherhood is a major life event, it has been examined as a crucial period for health behavior change based on the assumption that men will be less reluctant to change poor health behaviors given their new family responsibilities (Garfield et al., 2006; Kerr et al., 2011).

Kerr et al. (2011) examined fathers' substance use behaviors among primarily White resident fathers after the birth of their baby and found reductions in fathers' self-reported tobacco and alcohol use, especially among older fathers. Similarly, Garfield et al. (2006) found that their diverse sample of fathers from the Fragile Family Study were less likely to engage in risky behaviors and more likely to engage in physical activity after the birth of their baby. Although encouraging, further studies are needed to determine how paternal involvement may have encouraged fathers to adopt healthier behaviors beyond the transition to fatherhood. Additional research is also needed to determine whether fatherhood is associated with outcomes for fathers of older children, nonresident fathers, and fathers from diverse racial/ethnic backgrounds.

The Current Study

Based on previous research, we examined the extent to which different masculinity ideologies, perceived discrimination, and parenting behaviors were associated with depressive symptoms and drinking behavior among nonresident African-American fathers of preadolescent boys. We specifically examined the role of culturally based traditional and interconnected masculinity ideologies, fathers' coparenting with mothers, and the quality of relationship with their sons as protective factors against elevated depressive symptoms and drinking behavior. Hegemonic ideologies and perceived discrimination were examined as risk factors for outcomes given the precarious position of African-American men in this society and previous research indicating the deleterious consequences of both for depressive symptoms and drinking behavior among men. We also examined different masculinity ideologies as moderators of discrimination and parenting behaviors on outcomes to understand potential mechanisms for reducing depressive symptoms and drinking among nonresident African-American fathers.

Using a risk and resiliency framework, we conceptualized culturally based traditional and interconnected masculinity and parenting behaviors as compensatory factors. Compensatory factors are expected to neutralize exposure to risk and operate to protect against the negative consequences introduced by a risk factor (Zimmerman & Arunkumar, 1994). Thus, compensatory factors should have a direct and independent effect on outcomes. We also tested the protective/protective relationship between the culturally based masculinity ideologies and parenting behaviors on depressive symptoms and drinking behavior. The protective/protective model of resiliency suggests that one protective factor enhances the effects of another protective factor to predict less negative outcomes. Thus, we examined the moderating (i.e., interaction) effects between culturally based traditional and interconnected masculinity and the two parenting behaviors as a test of the protective/protective effects of a resiliency model of masculinity and fatherhood (Zimmerman & Arunkumar, 1994). This approach should be useful in planning mental health and health behavior interventions that incorporate cultural factors and parenting behaviors. Hegemonic masculinity and discrimination were risk factors within our framework.

Several hypotheses were tested: (1) African-American nonresident fathers who endorsed culturally based traditional and interconnected masculinity will report less depressive symptoms and drinking behavior, while those who endorsed hegemonic masculinity will report more of both outcomes, after controlling for demographic factors. (2) Perceived discrimina-

tion will be associated with more depressive symptoms and drinking behavior and it will account for additional variance after controlling for the effects of the demographic and masculinity factors. (3) Fathers' parenting behaviors will explain additional variance in both outcomes beyond the previous factors, with coparenting and quality of relationship with sons inversely related to both outcomes. (4) Masculinity ideologies will moderate the association between perceived discrimination and parenting behaviors on both outcomes such that culturally based traditional and interconnected masculinity will interact with both parenting behaviors to protect, whereas hegemonic masculinity will exacerbate the effect of perceived discrimination on outcomes.

Method

Sample

Data for the current study came from the Fathers and Sons Project, which included a family-centered youth risky behavior preventive intervention called the *Fathers and Sons Program*. This intervention program is designed to strengthen relationships between nonresident African-American fathers and their 8- to 12-year-old sons in an effort to prevent substance use, violent behavior, and early sexual initiation among sons. Details of the evaluation results are reported elsewhere (Caldwell, Rafferty, Reischl, De Loney, & Brooks, 2010).

For the purposes of the current study we combined the data from the intervention and comparison groups for fathers who completed the baseline questionnaire before the start of the intervention for a total sample size of 332 fathers. The two groups were alike on all demographic characteristics based on chi-square and *t* tests analyses except that comparison group fathers were more likely to have lived with their son, $\chi^2(1, n = 320) = 6.06, p = .014$, and to have lived with him longer than intervention group fathers, $\chi^2(3, n = 323) = 10.58, p < .05$. To account for these differences, we included "time lived with sons" as a covariate in multivariate analyses.

Table 1 presents the descriptive data for the sample. Fathers ranged in age from 22 to 63

Table 1
Descriptive Statistics for Sample Background Characteristics and Key Study Variables

Variable	*n*	Mean (*SD*)	Range	%	α
Demographic controls					
Age (yrs)	332	37.22 (7.69)	22–63		
Education	332				
Less than high school				21.99	
High school/GED				32.53	
More than high school				45.48	
Precarious family economic status	323			56.40	
Marital status	328				
Married, live with partner				28.62	
Widowed, separated, divorced				25.90	
Never married				45.48	
Ever lived with son	328			73.90	
Outcome measures					
Depressive symptoms	311	10.96 (5.23)	0–29		.68
Drinking behavior	324	1.84 (1.26)	0–4		
Masculinity ideologies					
Culturally-based traditional	283	38.20 (3.13)	8–40		.83
Hegemonic	290	17.46 (4.28)	5–25		.75
Interconnected	288	12.54 (2.09)	3–15		.62
Perceived discrimination					
Perceived discrimination	303	6.34 (2.85)	0–10		.82
Parenting behaviors					
Co-parenting	306	27.61 (5.16)	11–33		.88
Quality of relationship with son	328	3.30 (0.40)	1–4		.67

years old, with a mean age of 37.2 years, $SD = 7.6$. The majority of fathers (78.3%) had a high school/GED education or more, and about half (51%) were employed; however, most (56.4%) reported their economic status as having barely enough or not enough money to get by. Further, 29% were married or living with partner at the time of the study, and about 26% had never lived with their son who was in the study with them. Those who had lived with their son (about 74%) reported living with him until he was five years old or younger.

Procedures

Families were recruited from two Midwestern cities with similar characteristics. Details of the recruitment process are reported elsewhere (Caldwell et al., 2010). Consent for participation was obtained from the father and from the mother/guardian for the child because he was a minor. Assent was obtained from the child for his participation. Only nonresident fathers are included in the current study. This study was approved by the university's Health Sciences Institutional Review Board and an Institutional Review Board of a hospital in the city where the intervention was conducted because the Fathers and Sons Project is a community-based participatory research project (Israel, Eng, Schulz, & Parker, 2005) that involves a university, several community-based organizations, and the local health department in equal partnership in conducting the research. Study participants were paid a nominal amount for their involvement, and the baseline questionnaire took approximately 1-hr to complete.

Measures

Depressive symptoms. We used the Center for Epidemiologic Studies Depression Scale (CES-D, Radloff, 1977) to measure depressive symptomatology. This scale has good internal consistency with alphas of .85, split-half reliability coefficients ranging from .77 to .92, and test–retest correlations over 2 to 8 weeks ranging from .51 to .67. Excellent construct validity has been reported, correlating significantly with a number of other depression and mood scales (Radloff, 1977). This measure of psychological distress has often been used with African-American populations, including men. The original measure is a 20-item scale; however, we used the 12-item measure modified by Roberts and Sobhan (1992). Sample items are: "I felt depressed," "I had crying spells," "I felt hopeful about the future." Response categories were 0 (*rarely*) to 3 (*most or all the time*), with scale scores ranging from 0 to 36. A score of 9 and above indicates high depressive symptoms. Cronbach's alpha for the current sample = .68.

Drinking behavior. We created a composite measure of drinking behavior from three self-report items of alcohol use used in national studies with diverse samples (Johnston, O'Malley, & Bachman, 2000). Fathers were asked to respond to the following questions: "During the *past year*, how often did you drink a beer, glass of wine, or liquor?" The response scale ranged from 1 = *never* to 6 = *every day*. Fathers who drank were then asked the following: "During the past year when you drank beer, wine, or liquor, about how much did you usually drink on one occasion?" A composite score for alcohol use was created such that individuals who reported that they never drank received a score of 0, whereas scores among drinkers were: 1 = *1 can/glass per occasion*, 2 = *2 cans/glass*, 3 = *3 cans/glasses*, 4 = *4 cans/glasses or more per occasion*. Scale scores ranged from 0 – 4. Higher scores mean more drinks consumed per occasion, reflecting more problematic drinking behavior.

Masculinity ideologies. We relied on the 25-item Masculinity Salience Scale constructed from a content analysis of 152 African-American men's views about the meaning of manhood to measure masculinity ideologies (Hammond & Mattis, 2005). This scale measures multiple dimensions of the meaning of manhood constructed from theoretical themes that emerged from this work. The reliability of the original measure was tested with a community sample of 216 African-American men (Cronbach's alpha = .84). We factor analyzed the scale using an exploratory factor analysis with a varimax rotation, which resulted in a three-factor solution. We used a factor loading of .50 or higher as the cut point to include items on a factor which represented a specific masculinity ideology. No item loaded on more than one factor with this cut point. Factors 1–3 accounted for 22%, 14%, and 11% of the variance, respectively. The three masculinity factors were as follows: (1) culturally based tradi-

tional (Cronbach's alpha = .83), (2) hegemonic (Cronbach's alpha = .75), and (3) interconnected (Cronbach's alpha = .62).

The *culturally based traditional masculinity* subscale has eight items, such as "expressing love for family and friends," "being a good provider," and "being a good parent." The *hegemonic masculinity* subscale includes five items, such as "having power," "being physically strong," and "being in control of a relationship." And the *interconnected masculinity* subscale has three items, including "fighting for the rights of others" and "giving something back to the community." Fathers rated the importance of subscale items to their concept of being a man. Response categories were as follows: (1) not at all important, (2) a little important, (3) somewhat important, (4) quite important, and (5) extremely important. Subscale items were summed, with higher scores meaning more endorsement of the specific masculinity ideology. Culturally based traditional masculinity scores ranged from 8–40, hegemonic masculinity ranged from 5–25, and interconnected masculinity ranged from 3–15.

Perceived discrimination. The Everyday Discrimination Scale assesses chronic, routine, and less overt experiences with discrimination (Williams, Yu, Jackson, & Anderson, 1997). This 10-item measure captures frequency of perceived discrimination. It captures whether an event occurred and how often it occurred using responses ranging from 1 (*never*) to 6 (*almost every day*). Sample items are as follows: "People act as if they think you are dishonest" and "You are followed around in stores." We used the occurrence part of the questions. Reports of experiencing each discriminatory event were summed such that high scores reflect experiencing more types of discrimination. Scale scores could range from 0–10 with higher scores meaning more reports of different discriminatory experiences. Cronbach's alpha for the current sample = .82.

Coparenting. Fathers' coparenting with mothers was assessed using an 11-item scale that asked fathers to rank how often they agreed with their son's mother about the way that they were raising their son in several areas. Examples of these parenting areas are as follows: disciplining son, monitoring son's school progress, and communicating about drug use, violence, sex, and alcohol use. Fathers could respond that they (1) *never agree*, (2) *sometimes agree*, or (3) *always agree* with their son's mother about these parenting responsibilities. Responses were summed to form the coparenting scale, with scores ranging from 11 to 33. Higher scores mean more agreement about the way they were socializing their son. Cronbach's alpha = .88.

Quality of relationship with son. Quality of relationship with son is defined as how fathers feel about their relationship with their son. It assesses fathers' relationship with their son in several areas, including affectively and the quality of their interactions. Six items were adapted from the Social Networks and Adult Attachment Questionnaire (Antonucci, 1986) to assess quality of the father-son relationship. Sample items are as follows: How often do you . . ."feel close to your son," "disagreed with him," "feel he gets angry with you." Response categories ranged from (1) *never* to (4) *all the time*. Negative items were reversed so that higher mean scores indicate a more positive relationship with sons. Cronbach's alpha = .67. This measure has been used in regional and national studies with African-American adults and children.

Demographic Controls

Age, education, marital status, and employment were measured with standard demographic questions. Perceptions of economic status were assessed with a single question that asked fathers the following: How would you describe your financial situation today? Response categories were: 1 = *not enough to get by*, 2 = *barely enough to get by*, 3 = *enough to get by, but no extras*, and 4 = *more than enough to get by*. Fathers were asked if they had ever lived with their son, but only fathers who had ever lived with their son were asked how long they had lived together. Specifically, fathers were asked the following: Have you ever lived in the same house with your son who is here with you today? If, yes, How long did you live with your son? The following response categories were used–-until he was (a) less than one year old; (b) 1–5 years old, (c) 6–7 years old, (d) 8–10 years old, and (e) 11–12 years old. These categories were selected to represent important developmental milestones and to reflect critical age demarcations for the Fathers and

Sons Project (i.e., 8–10, 11–12). Scores ranged from 0 = *never lived together* to 5 = *until son was 11 to 12 years old*.

Data Analytic Strategy

Analyses were conducted using SPSS 17.0. Frequencies, means, and standard deviations were calculated for descriptive results. Hierarchical regression analyses were conducted to determine the masculinity ideologies, perceived discrimination, and parenting behavior factors' contributions to explaining variance in depressive symptoms and drinking behavior after controlling for demographic variables entered on Block 1. We entered the masculinity variables on Block 2 to determine the association between these ideologies and outcomes and whether additional variance was accounted for after the demographic controls. Perceived discrimination was entered on Block 3, whereas the two parenting behaviors were entered on Block 4 to determine their association with fathers' depressive symptoms and drinking behavior, as well as the contribution of this factor after controlling for all other factors. Finally, the interaction terms were entered on Block 5 with the three masculinity ideologies as moderators of perceived discrimination and the parenting variables (i.e., masculinity ideologies × perceived discrimination, masculinity ideologies × coparenting, and masculinity ideologies × quality of relationship with son) to determine whether perceived discrimination and parenting behaviors on outcomes varied by different masculinity ideologies as hypothesized. The moderators, masculinity ideologies, were dichotomized based on mean splits before creating the interaction terms.

Missing data. To maximize the sample, missing data were replaced using maximum likelihood estimates for parameters in probabilistic models via the Estimation-Maximization (EM) algorithm. We created a dichotomous variable for all variables with incomplete data and conducted bivariate and multivariate logistic regression analyses to demonstrate that the data were likely missing at random. We replaced missing data using the estimation maximization technique because it has been shown to produce less biased parameter estimates than deleting all cases with missing data (Fox-Wasylyshyn and El-Masri, 2005).

Results

Descriptive Results

Table 1 provides the descriptive results for key study variables. Findings indicated that fathers, on average, had elevated levels of depressive symptoms, $M = 10.96$, $SD = 5.23$, and consumed about two drinks, $SD = 1.26$, on one occasion, whereas approximately 37% of fathers said that they never drank. On average, fathers reported high levels of culturally based traditional, $M = 38.20$, $SD = 3.13$, hegemonic masculinity, $M = 17.46$, $SD = 4.28$, and interconnected masculinity, $M = 12.54$, $SD = 2.09$. They also reported six of 10 discriminatory experiences during the previous year. These nonresident fathers engaged in high levels of cooperative parenting or coparenting with their sons' mother, $M = 27.61$, $SD = 5.16$, and indicated generally positive relationships with their son, $M = 3.30$, $SD = 0.40$.

Based on bivariate analysis, depressive symptoms and drinking behavior were positively correlated. Depressive symptoms among fathers were positively correlated with their perceptions of hegemonic masculinity beliefs and perceptions of discrimination and negatively correlated with education, family economic status, culturally based traditional and interconnected masculinity beliefs, and quality of relationship with son (see Table 2). Drinking behavior was inversely associated with education, coparenting, and quality of relationship with son. None of masculinity beliefs were significantly correlated with drinking behavior.

Multivariate Findings: Depressive Symptoms

Table 3 presents the results of the hierarchical regression analysis for depressive symptoms. Results indicate that more culturally based masculinity was associated with less depressive symptoms after controlling for demographic factors. Hegemonic masculinity was only marginally associated with more depressive symptoms as indicated in Model 2. The introduction of the masculinity factor explained an additional 3% of variance in depressive symptoms over the demographic control variables in Model 1, $F(3, 321) = 3.73$, $p = .016$. The

Table 2
Correlation Matrix of Depressive Symptoms, Drinking, Demographic Controls, Masculinity, Discrimination, and Parenting Variables

	1	2	3	4	5	6	7	8	9	10	11	12
1. Drinking behavior	—	.11*	−.04	−.13*	−.06	−.03	.09	−.07	−.08	.09	−.11*	−.15**
2. Depression symptoms			−.05	−.13*	−.16**	.03	−.24**	.14*	−.20**	.35**	−.08	−.32**
3. Age				−.01	.06	.03	.05	.03	.15**	.10	.02	−.06
4. Education level					.31**	.05	.09	−.02	.03	.00	.05	.09
5. Financial situation						−.05	.13*	−.04	.08	−.04	.07	.21**
6. Time lived with son							.05	.01	−.02	.11*	−.04	−.03
7. Masculinity: culturally-based traditional								.07	.48**	−.12	.11	.18**
8. Masculinity: hegemonic									.18**	.01	.09	.01
9. Masculinity: interconnected										−.16**	.21**	.19**
10. Perceived discrimination											−.13*	−.31**
11. Co-parenting												.14*
12. Quality of relationship with son												—

* Correlation is significant at the 0.05 level (2-tailed). ** Correlation is significant at the 0.01 level (2-tailed).

overall model was significant $F(10, 321) = 4.08$, $p < .000$, $R^2 = .11$.

Perceived discrimination was entered in Model 3, and the model was significant, $F(11, 320) = 8.30$, $p < .000$, $R^2 = .22$. As expected, perceiving more discrimination was associated with more depressive symptoms. Adding this factor to the model explained 11% more variance in depressive symptoms. The parenting factor entered in Model 4 explained another 3% of the variance in depressive symptoms, with only quality of relationship with sons emerging as a significant variable. That is, a more positive relationship with sons was associated with less depressive symptoms among fathers. Culturally based traditional and hegemonic masculinity ideologies and perceived discrimination were also significant predictors in this model. The overall model was significant, $F(13, 318) = 8.34$, $p < .000$, $R^2 = .25$, accounting for 25% of the variance in nonresident African-American fathers' depressive symptoms. In addition to age, education, and marital status, time lived with sons before living apart was associated with depressive symptoms among control variables, indicating the less time fathers lived with their sons before becoming nonresident the more current depressive symptoms they reported.

Finally, interaction terms were entered in Model 5 to test the moderating effects of the masculinity ideologies with discrimination, coparenting, and quality of relationship with son. The overall model was significant, $F(22, 309) = 5.50$, $p < .000$, $R^2 = .28$. However, only one significant interaction was found. Interconnected masculinity moderated the relationship between coparenting and depressive symptoms. That is, coparenting was associated with more depressive symptoms among fathers with high interconnected masculinity.

Multivariate Findings: Drinking Behavior

Table 4 presents the results for drinking behavior. None of the masculinity ideologies were associated with fathers' drinking behavior after controlling for the demographic factor. Perceived discrimination did not contribute any additional explanatory power for drinking behavior, although the model was significant, $F(11, 320) = 2.12$, $p = .018$, $R^2 = .07$.

Table 3
Hierarchical Regression Analysis of Predictors of Depressive Symptoms in Nonresident African-American Fathers (n = *332*)

Variable	Model 1		Model 2		Model 3		Model 4		Model 5	
	B	*SE B*	*B*	*SE B*	*B*	*SE B*	*B*	*SE B*	*B*	*SE B*
Demographic controls										
Age	−.06	.04	−.04	.04	−0.07$^{@}$	.04	−.07*	.04	−.08*	.04
Education[a]										
High school/GED	−1.21	.77	−1.32$^{@}$	.76	−1.28$^{@}$	.71	−1.30$^{@}$	.70	−1.50*	.71
More than high school	−1.43$^{@}$	.76	−1.50*	.75	−1.52*	.70	−1.42*	.69	−1.54*	.69
Precarious family economic status	−1.18*	.58	−1.02$^{@}$	.58	−0.87	.55	−.46	.55	−.36	.56
Marital status[b]										
Widowed, separated, divorced	2.03*	.77	1.86	.77	1.71*	.72	1.64*	.71	1.65*	.72
Never married	.59	.66	.42	.66	.52	.62	.66	.61	.53	.62
Time lived with son	−1.88*	.63	−1.8**	.62	−1.96**	.58	−1.73**	.57	−1.72**	.58
Masculinity ideologies										
Masculinity: culturally-based			−1.26*	.61	−1.11$^{@}$	.57	−1.24**	.57	−3.34	5.93
Traditional										
Masculinity: hegemonic			1.07$^{@}$	.58	1.00$^{@}$	.54	1.07*	.53	.47	5.73
Masculinity: interconnected			−0.89	.61	−.26	.58	−.09	.57	−8.33*	3.87
Perceived discrimination										
Perceived discrimination					.61***	.09	.50***	.09	.36*	.16
Parenting										
Coparenting							−.01	.04	.02	.08
Quality of relationship with son							−.60***	.16	.86	1.50
Interactions										
Culturally-based traditional × discrimination									−.17	.21
Hegemonic × discrimination									.27	.20
Interconnected × discrimination									.20	.21
Culturally-based traditional × co- parenting									−.14	.12
Hegemonic × co-parenting									.05	.10
Interconnected × co-parenting									.25*	.12
Culturally-based traditional × quality of relationship									.57	.36
Hegemonic × quality of relationship									.01	.36
Interconnected × quality of relationship									−.07	.06
R^2	.08***		.11***		.22***		.25*		.28***	
Change in R^2			.03*		.11***		.03**		.03	

[a] Less than high school reference group. [b] Married reference group.
$^{@}$ $p < .10$. * $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4
Hierarchical Regression Analysis of Predictors of Nonresident African-American Fathers' Drinking Behavior (n = *332*)

Variable	Model 1		Model 2		Model 3		Model 4		Model 5	
	B	*SE B*	*B*	*SE B*	*B*	*SE B*	*B*	*SE B*	*B*	*SE B*
Demographic controls										
Age	−.01	.01	−.01	.01	−.01	.01	−.01	.01	−.01	.01
Education[a]										
High school/GED	−.54**	.19	−.54**	.19	−.54**	.19	−.53**	.19	−.58**	.19
More than high school	−.46*	.19	−.44*	.19	−.45**	.19	−.42*	.19	−.41*	.19
Precarious family economic status	−.07	.15	−.09	.15	−.08	.15	−.02	.15	−.02	.15
Marital status[b]										.
Widowed, separated, divorced	−.06	.19	.05	.19	−.05	.19	−.01	.19	−.04	.20
Never married	.01	.17	.01	.17	.02	.17	.04	.16	.02	.17
Time lived with son	.46**	.16	.45**	.16	.44*	.16	.48**	.15	.48**	.16
Masculinity ideologies										
Masculinity: culturally-based traditional			.17	.15	.17	.15	.16	.15	−2.40	1.61
Masculinity: hegemonic			−.11	.14	−.12	.14	−.10	.14	−2.39	1.55
Masculinity: interconnected			−.10	.15	−.06	.15	−.02	.15	.84	1.05
Perceived discrimination										
Perceived discrimination					.04	.02	.02	.02	.01	.04
Parenting										
Coparenting							−.02	.01	−.03	.02
Quality of relationship with son							−.10*	.04	.18	.41
Interactions										
Culturally-based traditional × discrimination									.05	.06
Hegemonic × discrimination									.03	.06
Interconnected × discrimination									−.04	.06
Culturally-based traditional × co-parenting									.03	.03
Hegemonic × co-parenting									−.00	.03
Interconnected × co-parenting									−.02	.03
Culturally-based traditional × quality of relationship									.10	.10
Hegemonic × quality of relationship									.17@	.10
Interconnected × quality of relationship									−.01	.02
R^2	.06**		.06*		.07*		.09**		.12*	
Change in R^2			.01		.01		.02*		.02	

[a] Less than high school reference group. [b] Married reference group.
@ $p < .10$. * $p < .05$. ** $p < .01$. *** $p < .001$.

The addition of the parenting behavior factor explained another 2% of variance in fathers' drinking behavior. Again, only quality of relationship with son was significant. A more positive relationship with sons was associated with less drinking among fathers. This model accounted for 9% of the variance in drinking behavior, and it was significant, $F(13, 318) = 2.95$, $p < .001$, $R^2 = .09$. Two control variables were consistently associated with fathers' drinking behavior: education level and time lived with sons. Fathers with less than a high school education and those who lived longer with their sons reported more drinking when compared with fathers with high school or more education and those who did not live with their sons as long.

The final interaction model was significant, $F(22, 309) = 1.82$, $p = .014$, $R^2 = .11$, accounting for an additional 2% of variance in drinking behavior. However, the quality of relationship and hegemonic masculinity interaction was only marginally significant.

Discussion

We examined associations between masculinity, perceived discrimination, and parenting behaviors on depressive symptoms and drinking behavior among nonresident African-American fathers. The goal was to consider different dimensions of masculinity ideologies and parenting behaviors as protections against depressive symptoms and drinking among men who are often in precarious positions within American society and within their families as a result of historical discrimination and more limited involvement with their children. Our findings show that masculinity ideologies are multidimensional and differentially associated with depressive symptoms. These results were not replicated, however, for drinking behavior. We also found that quality of relationship with sons is associated with less depressive symptoms and drinking. Thus, masculinity and relationship factors may be critical for understanding how to better address the mental health and health behaviors of nonresident African-American fathers.

Multidimensional Masculinity Ideologies as Risk or Protective Factors

The identification of hegemonic ideologies among fathers with characteristics such as being powerful, in control, and physically strong is not surprising as Connell and Messerschmidt (2005) described a hierarchy of masculinities with hegemonic ideologies being dominant. They also noted the plurality and dynamic nature of masculinities, explaining that hegemonic ideologies may not be the most common for all men. Indeed our findings confirm the significance of culturally based traditional belief systems among nonresident African-American fathers that emphasizes the importance of expressing love for family and friends, as well as more traditional masculinity norms such as being a good provider, protector, and successful on the job. Interpersonal connections external to family and friends characterized by fighting for the rights of others and giving back to the community emerged as a separate masculine belief system among these fathers. Culturally based traditional and interconnected ideologies are consistent with masculine belief systems identified in previous qualitative studies with African-American men (Hunter & Davis, 1994; Hammond & Mattis, 2005). The identification of multiple dimensions of masculinity among nonresident African-American fathers who are often marginalized within society, within institutions and systems, and sometimes within their families suggests a need for masculinity ideologies that are adaptive in specific contexts (Phillips, 2001). Thus, a multidimensional approach to masculinity is supported by our findings for these fathers.

Consistent with our hypothesis, endorsement of more culturally based traditional masculinity ideologies are associated with less depressive symptoms. Perhaps this reflects the importance of family and friends because our expectation for more endorsement of interconnected ideologies was not supported. It may be that beliefs about manhood related to family are critical for understanding positive mental health among nonresident fathers. Simply understanding interpersonal competencies outside of family may not be sufficient to fully delineate potential mental health protections for these men.

Interestingly, culturally based traditional ideologies may not be protective against drinking behaviors for fathers. Jackson and colleagues (2010) have argued that studies often find lower rates of depression among African Americans than Whites because of adaptive strategies used to mask emotional traumas that manifest in

health risk behaviors such as drinking among men and unhealthy eating among women, representing ineffective ways of coping with the stressors of life. Given that fathers with less education and those who lived with their sons longer before becoming nonresident engage in more drinking in this study, the life stressors explanation is plausible. Perhaps nonresident fathers who are able to meet family obligations are protected against depressive symptoms by culturally based traditional ideologies, whereas those who cannot drink more as a response to vulnerability in the family provider role. This drinking finding is consistent with a wealth of research that describes the positive association between traditional masculinity and risky health behaviors among men (Mahalik, Burns, & Syzdek, 2007; Mullen et al., 2007; Tannenbaum & Frank, 2011). The meaning of this association may be different for nonresident African-American fathers than for men with traditional masculinity ideologies that include power and control. Future research is needed to clarify these issues.

We found an association at the bivariate level and at the multivariate level of the expected trend toward nonresident African-American fathers who endorse more dominant hegemonic ideologies expressing more depressive symptoms. These findings are more closely aligned with previous studies finding poorer mental health for men who reported more masculinity beliefs emphasizing power, physical strength, and control (Connell & Messerschmidt, 2005; Levant, Wimer, & Williams, 2011). Hegemonic ideologies may place nonresident fathers at a disadvantage as they suggest rigidity and less flexibility in interpersonal relationships that may be required to function as part of family systems across multiple households. The negotiations necessary to be part of their children's lives require relinquishing some power and control in favor of collaborative relationships with the mother of their children. This may be difficult to achieve and thus is perhaps associated with more depressive symptoms for these fathers (Anderson et al., 2005; Wilson & Brooks-Gunn, 2001). This relationship was strongest in the presence of the parenting factor with hegemonic masculinity as a moderator of coparenting and depressive symptoms. This relationship approached significance. Future research will be necessary to fully test these ideas with stronger measures and a larger sample.

Fatherhood as a Context for Men's Health

We included nonresident fathers with preadolescent sons in this study; children who are old enough to verbalize their needs to their fathers. We found that having a positive relationship with sons was protective against depressive symptoms and drinking for fathers. The masculine norm of emotional detachment or emotional isolation may not be operative for nonresident fathers who are involved with their children, perhaps because they must make extra efforts to engage with them under very challenging circumstances (Sobolewski & King, 2005). Our prior research has shown that nonresident African-American fathers who have better mental health are more involved with their children (Davis et al., 2009). The direction of this relationship is unclear because the literature has been more consistent about documenting the tendency for depressed mothers to minimize time spent with their children, limit physical contact, and engage in poorer parenting behaviors (Campbell, Morgan-Lopez, Cox, & McLoyd, 2009; Lyons-Ruth, Wolfe, Lyubchik, & Steingard, 2002). Umberson and Williams (1993), who were studying the roots of depression among divorced fathers, found that spending less time and a limited exposure to their children were associated with more stress in White fathers. They concluded that this type of parenting stress may be a risk factor for depression among men. Long-term longitudinal studies are needed to provide more confidence in the direction of the relationship between parenting and mental health among fathers.

Our findings point to the critical role that fatherhood as a social context can play in understanding men's mental health and health behaviors. Mahalik and Burns (2011) examined the role of the social environment on the social norms of primarily White men regarding health promoting behaviors. They found that the perceived social norms of others were important in predicting health behaviors above individual beliefs. Quality of relationship with sons appears to be a vital part of the social environment of nonresident African-American fathers that may have added value for understanding their health and well-being.

Although prior studies have found better coparenting between nonresident fathers and the mother of their children was associated with less depressive symptoms (Wilson & Brooks-Gunn, 2001), we did not replicate this finding. We anticipated a protective-protective effect of coparenting and the two culturally based masculinity ideologies on outcomes when there was high agreement between parents in raising their son. Instead we found that high coparenting agreement was linked to more depressive symptoms among fathers with more interconnected masculinity ideologies. This finding suggests a complex pattern of relationships between masculinity beliefs and interpersonal competencies involving mothers and fathers' commitment to others outside of the family. Perhaps socialization goals operationalized in efforts to coparent may result in oppositional or conflicting feelings for African-American fathers who are drawn toward social justice issues. Thus high coparenting may be associated with more depressive symptoms for these fathers. Specifically, nonresident African-American fathers who believe in fighting for the rights of others and for community (interconnected masculinity) may be unable to adequately balance the social norms for fatherhood and activism given their residence status (Sobolewski & King, 2005). High coparenting agreement with mothers may be the price these fathers pay to be involved with their children at the expense of their mental health. The benefits of fatherhood for nonresident African-American men's mental health may be diminished depending on the conditions under which they adopt masculinity beliefs involving interpersonal competencies with others in the presence of coparenting responsibilities. This is an important area for future research to explore to better understand the nature of these complex relationships and the balance needed for successful mental health functioning for African-American fathers.

Like the Hammond (2012) study, we found that perceived discrimination is associated with more depressive symptoms. This is not surprising based on research showing that African-American men experience greater vulnerability to the harmful effects of racism (Franklin, 1999; Utsey & Payne, 2000). Ultimately, racism perpetuates feelings of anger, stress, anxiety, and depression and serves as a consistent reminder of African-American men's lower social status in American society (Franklin, 1999; Utsey & Payne, 2000). We did not find interactions between masculinity ideologies and discrimination for depressive symptoms or drinking. Unlike the Hammond (2012) study, discrimination appears to be associated with depressive symptoms independent of the masculinity ideologies we examined for nonresident fathers.

Implications for Intervention, Clinical Practice, and Policy

The results of our study are promising for advancing future research on men's health and family studies. They also have implications for intervention and clinical practice. Based on interaction results, masculinity ideologies may be used in tailoring intervention programs designed to address depressive symptoms and nonresident African-American fathers. Our findings for depressive symptoms, for example, suggest that fathers with more interconnected masculinity ideologies may benefit from intervention programs that address coparenting with mothers. In practice, fathers could be evaluated for their masculinity beliefs in intervention and clinical practice settings to tailor or better plan for determining coparenting strategies for establishing socialization goals that adequately incorporate fathers' opinions. Nonresident fathers often rely on collaborative coparenting with mothers to maintain involvement with their children. Our findings suggest that nonresident African-American fathers with more interconnected masculinity beliefs may be ineffective in their coparenting negotiations with mothers. These fathers could benefit from assistance in efforts to reduce depressive symptoms.

Strengthening relationships between nonresident African-American fathers and sons is also warranted by our findings as this relationship appears to be protective for fathers' depressive symptoms and drinking behavior. From a policy perspective, there are many policies in place to assist mothers and children, but few to support fathers and children. Findings from our study suggest the need for institutional policies (e.g., school, work, health care system) to incorporate the significance of fatherhood into their planning efforts for *involved* nonresident African-American fathers. For example, special outreach to fathers and sons together for health fairs and intervention programs, offer opportunities for fathers to assume the role of health educator in their son's life, but

also time to be together to strengthen the bond between fathers and sons. Routine doctor's visits can also screen for specific relationship information with children. Nonresident African-American fathers in need of help with their drinking may find such outreach efforts especially beneficial, regardless of their masculinity ideologies.

Several limitations must be noted to provide a context for study findings. First the results of this study are based on cross-sectional data; therefore, causal attributions cannot be made. Although we suggest that having a good relationship with sons may influence depressive symptoms and drinking behavior among nonresident fathers, it is just as plausible that fathers with high levels of depressive symptoms and those who drink more are not able to form good relationships with their sons. Because nonresident fathers' behavior often determines whether they will be allowed to be involved with their children by external forces (e.g., mothers, courts), it is likely that fathers who do have access to their children may be better functioning than those who do not. Future longitudinal research is needed to clarify the direction of these relationships. Second, we relied on self-report data from fathers alone; therefore, there is no way to verify the accuracy of the responses provided. This raises the issue of method variance that could have been avoided if multiple respondents, such as the sons' mother, had been included in the study or if multiple methods of collecting the data had been used. As an initial study in this area, however, this study provides data that are useful as a foundation for future research in an area that is understudied.

Third, we used a convenience rather than a random sampling procedure; therefore, we do not have a representative sample of nonresident African-American fathers. The final sample may be more involved and engaged fathers rather than nonresident father who would not have participated in a research study. We did, however, find adequate distributions on all measures of interest. Finally, the reliabilities of three measures ranged from .62–.68, less than the desirable .70, but indicating some reliability for the sample. Future studies should include stronger measures, especially for interconnected masculinity ($\alpha = .62$) to confirm study findings.

Our findings make important contributions toward understanding the role of masculinity and parenting behaviors in the mental health and health behaviors of nonresident African-American fathers. We know that nonresident status puts African-American fathers at higher risk for poor health outcomes compared with other men (Spector, 2006). We found that having a positive relationship with their sons is associated with less depressive symptoms and drinking behavior for these fathers. Identifying ways to better connect nonresident African-American fathers with their children may be a promising direction for future efforts focused on preventing depression or reducing drinking among these fathers. As suggested by Garfield et al. (2006) in a commentary in the *Journal of the American Medical Association,* "illuminating the psychosocial fabric of men's lives may reveal critical links between fatherhood and men's health" (p. 2368). Further determining the conditions under which different dimensions of masculinity may be protective or a risk factor for mental health and health behaviors when combined with specific parenting behaviors among specific groups of men will help to specify the contributions of fatherhood to men's health. Understanding the benefits and burdens of fatherhood as a social context for health will provide practitioners, clinicians, and policymakers with additional information to use in finding ways to reduce or eliminate health disparities among men.

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